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Questions and Answers about Hypothyroidism and Pregnancy

By Christy Van Orman, R.N. B.S.N.

What is the thyroid and what is hypothyroidism?

The thyroid is a small gland located in the neck that produces an important hormone for controlling growth, heat production, and fertility. If the thyroid gland produces too little thyroid hormone, a medical condition called hypothyroidism occurs.¹ Low thyroid hormone levels are concerning because, if untreated, they can cause problems in pregnancy and fetal development.²

"Hypothyroidism

occurs in about 4-17%

of women during their

childbearing years."

How common is hypothyroidism?

Hypothyroidism occurs in about 4-17 percent of women during their childbearing years.¹

What advice can be given to a pregnant woman with hypothyroidism?

- See her doctor or midwife as soon as she finds out she is pregnant, or at least by 10 weeks of pregnancy. At her prenatal care visit, discuss treatment of hypothyroidism during pregnancy with her care provider.³
- Assure her not to worry! With proper care and treatment, she has every chance of having a healthy pregnancy and birth.
- Take her thyroid medication each day as directed. Be careful not to miss a dose.³
- Have her blood thyroid levels (TSH, T3 and T4) checked at least every three months, or more often as needed to keep them in normal range during pregnancy.^{2,4}
- Expect that she may need to change the dose of her thyroid medication during and after her pregnancy.⁴

(See Hypothyroidism, page 2).

Hypothyroidism (from p. 1)

Can low thyroid levels increase a baby's risk of low IQ?

A study in the New England Journal of Medicine showed that babies born to mothers with untreated hypothyroidism during pregnancy are four times more likely to have low IQ or other learning difficulties.⁵ However, children of mothers with thyroid levels in the normal range had IQ test scores similar to children born to mothers without thyroid disease.

Is it safe to take a thyroid hormone pill during pregnancy?

It is not only safe, but also very important for expectant mothers with hypothyroidism to take their thyroid replacement medication during pregnancy. These medications (Synthroid, Levoxyl, Levothroid, Armour, or Thyrolar) replace the normal hormones needed for a healthy pregnancy.³ Without enough thyroid hormone, there is an increased risk of miscarriage, high blood pressure, preterm labor, and problems with fetal brain development.^{2,6,7}

Is it ok to take thyroid medication with prenatal vitamins or with food?

Prenatal vitamins, iron supplements, antacids, and certain foods interfere with the body's absorption of thyroid hormone. Since it is critical for the body to get enough thyroid hormone during pregnancy, women should take their thyroid medication daily, at least one hour before or two hours after meals. Prenatal

vitamins and antacids should not be taken within two hours of taking thyroid medication. Consistency is important. If taking the thyroid pill without food is not always possible, it is better to take it every day with food than to miss some days.³ If the expectant mother cannot keep the thyroid pill down because of nausea and vomiting, she should notify her care provider.

Can a mother breastfeed her baby while taking thyroid medication?

Women with hypothyroidism should be encouraged to breastfeed their babies. Nursing mothers should continue to regularly check their thyroid hormone levels and take their thyroid replacement medication while nursing. In correct dosages, thyroid medication enters the breast milk in very small amounts that will not harm a nursing baby. A normal level of thyroid hormone is required for a mother to produce sufficient breast milk for her baby.^{3,8}

Will the baby have hypothyroidism, too?

All babies born in the United States are tested for hypothyroidism soon after birth as part of a routine metabolic screening program.² Congenital hypothyroidism is very rare in infants, occurring at a rate of 1 per 4,000 to 5,000 births.^{1,3} If thyroid disease is passed on genetically, it usually does not appear until the second decade of life.³

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ANNOUNCEMENTS...

Smoke Free Families Training: Implementing the 5As to Encourage Smoking Cessation Among Pregnant Patients

The Smoke Free Families Training will be held April 15, 2002, at 5:30 pm at the University Park Marriott in Salt Lake City. For more information, contact Lois Bloebaum at (801) 538-6792.

Utah Public Health Association's Annual Conference

The Utah Public Health Association's annual conference will be held April 24-26, 2002 at the Park City Marriott in Park City. For more information, go to the UPHA website at www.upha.org

Utah Nurse Practitioners' Annual Pharmacology Conference

The 9th Annual Utah Nurse Practitioners' Pharmacology Conference will be held April 26-27, 2002 at the Huntsman Cancer Institute in Salt Lake City. 10 CEUs are available. For more information, send an e-mail message to utahnp76@hotmail.com

Screening for Postpartum Depression

By Debby Carapezza, F.N.P.

Each year in the United States, 15 to 20 percent of adults experience a major depression. Among women, the incidence of depression is twice that of men and peaks between 18 and 44 years of age – the childbearing years. Women are at an increased risk for mood disorders throughout periods of hormonal fluctuation occurring during premenstrual, postpartum or perimenopausal periods.¹ Postpartum mood disorders range in severity. Within the first two weeks following delivery, 50 to 80 percent of women experience mild, transient “baby blues”. At the other end of the depression spectrum is the most severe form of post-delivery mood disorder, postpartum psychosis. While postpartum psychosis is experienced by only 0.1 to 0.2 percent of women, it constitutes an emergency requiring immediate referral for psychiatric care. Midrange in the spectrum is postpartum depression (PPD), also known as postpartum major depression (PMD). Depending on diagnostic criteria utilized, nationally PMD affects 6.8 to 16.5 percent of women.^{1,2} However, among 1999 Utah PRAMS* respondents, 25.3 percent of mothers surveyed reported they were moderately to very depressed in the months after delivery.³

Onset of PMD symptoms ranges from 24 hours to several months following delivery.^{1,2} Symptoms of PMD include feelings of hopelessness, helplessness, persistent sadness, irritability, low self-esteem, sleep or appetite disturbances, inability to concentrate, and loss of pleasure in activities.⁴ Left untreated, these symptoms may persist into the second year postpartum, leaving the mother with limited coping capacity and decreased ability to perform activities of daily living.² This loss impacts not only the woman, but also her child. Studies indicate that infants of depressed mothers express more negative emotions and have decreased cognitive development compared to infants of non-depressed mothers.⁵

Risk factors for developing PMD have been identified. They include family or client history of mood disorder; anxiety/depression during pregnancy; postpartum depression following previous deliveries; baby blues with current delivery; child care difficulties (infant feeding, sleep or health problems); marital conflict; stressful life events; and poor social support.² Utah PRAMS data for 1999 yielded similar findings. Women who reported being moderately or very depressed in the months after delivery were more likely to have less than a high school education; be 19 years of age or younger; live in a household earning \$15,000 or less annually; have experienced an unintended pregnancy; report being abused during pregnancy or 12 months before the pregnancy; have one or no support persons; be unmarried; or report seven to 13 stresses during pregnancy (e.g., sick family member, divorce).³ (See Depression, Page 4).

*PRAMS-Pregnancy Risk Assessment Monitoring System is an ongoing, population-based risk factor surveillance system designed to identify & monitor selected maternal experiences before & during pregnancy, & experiences of the child's early infancy.

Depression (from p. 3)

Despite these identifiable risk factors and the relative prevalence of this very treatable disorder, many women suffer in silence. Women may be hesitant to mention the problem or feel that their experience is a normal part of new motherhood. Others feel admitting to negative feelings regarding motherhood will brand them as “bad” mothers, or they may fear they are “going crazy” and their babies will be taken from them.¹

In Utah in recent years, there were two suicide deaths by women within one year of giving birth. Neither woman had been screened for PMD.⁶ As postpartum depression may not have its onset until after the woman has been discharged from obstetrical care, it is important for all providers having contact with new mothers to screen for this disorder. PMD screening should occur as a part of not only obstetrical care, but also at routine family planning visits, well child exams, infant immunizations, WIC clinic visits, and as a part of a woman’s routine episodic health care. Treatment of PMD may consist of individual or group counseling, drug therapy and/or support groups. Provision of drug therapy for breastfeeding mothers must be made case by case, but breastfeeding does not automatically exclude a woman from this potentially life saving treatment modality.

Several PMD screening tools are available, including the Center for Epidemiological Studies Depression

Scale (CES-D),⁷ the Beck Depression Inventory – II,⁸ and the Edinburgh Postnatal Depression Scale (EPDS).⁹ Whatever tool is utilized, it is important to be familiar with its validity and limitations. Also, it is important to have a referral network available for women screening positive for PMD and to document screening and referrals. Regardless of the screening tool utilized, even if the client’s score is considered within normal limits, if the clinician feels the client is suffering from depression, an appropriate referral should still be made. These tests are only screening tools. They do not diagnose depression – that is done by physicians /psychiatrists or appropriately licensed advanced practice registered nurses. If a formal “paper and pencil” approach to screening for postpartum depression is not utilized, familiarity with screening questions may assist in assessing clients via verbal histories.

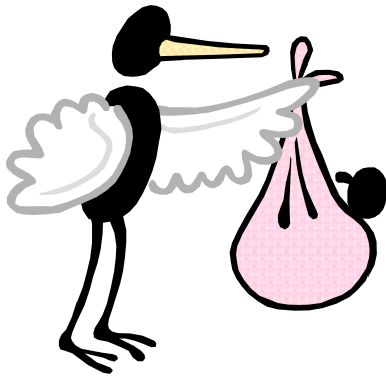
Screening, referral and appropriate treatment of women for postpartum depression has the potential to reduce unnecessary suffering, the negative impact of PMD on infant development, and the risk of suicide. A copy of the EPDS and websites with PMD information can be found throughout this newsletter.

“In Utah in recent years, there were two suicide deaths by women within one year of giving birth.”

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**Check out the
following websites on
Hypothyroidism and
Pregnancy...**

[www.mythyroid.com/
pregnancy.htm](http://www.mythyroid.com/pregnancy.htm)

[www.endocrineweb.com/
pregnancy.html](http://www.endocrineweb.com/pregnancy.html)

[www.thyroid.about.com/cs/
pregnantfertility/](http://www.thyroid.about.com/cs/pregnantfertility/)



Medicaid Offers Smoking Cessation Services for Pregnant Women

By Julie Olson

Pregnant women enrolled in Medicaid may receive smoking cessation services, including social support, skills training in problem solving techniques, and access to pharmacological aids if recommended by their physician.

Women smoke for various reasons, including weight control, stress management, depression, and nicotine addiction. Pregnant women need services to address their special needs. The services funded by Medicaid are designed to meet their needs in the following ways:

- Offer support to help pregnant women quit smoking
- Focus on lifestyle, weight gain, as well as social and emotional issues facing pregnant women
- Teach strategies to help pregnant women quit smoking for life
- Provide pharmacological aids when appropriate (these can only be prescribed by her physician and they require a simple prior approval process)

Medicaid has approved seven smoking cessation programs whose services meet the special needs of pregnant women. These programs are in the following health departments: Salt Lake Valley, Southwest Utah, Tooele County, Utah County, Davis County, Southeastern Utah, and Central Utah. For women who would like to quit, but have no available program in their local area, Medicaid has available a written self-help guide for pregnant women. In addition, Medicaid staff will offer follow-up telephone calls to women using the self-help guide.

Women enter the program through various routes. Pregnant women are screened during the Medicaid eligibility process. Those that report being a smoker are contacted by Medicaid staff, who assess the woman's readiness to quit smoking. Women who say they are ready to quit are given referrals to the approved programs or offered a self-help program. Each woman receives follow-up calls to check her progress or to offer additional services. Women are also referred into the program through the Women, Infants and Children (WIC) Program and through health maintenance organizations. Women may self-refer into the program as well by contacting the health program representative in her local eligibility office or by calling 801-538-6303. Women outside of the Wasatch Front can call 1-800-662-9651 and ask to be transferred to Julie Olson (or extension 538- 6303).

WEBSITES AND OTHER RESOURCES

Websites with Information about Postpartum Depression...

Depression After Delivery
www.depressionafterdelivery.com

Postpartum Support
International
www.postpartum.net/

The Postpartum Stress Center
www.postpartumstress.com/

Postpartum Education for
Parents
www.sbpep.org

Office on Women's Health
[www.4women.gov/search/
search/cfm](http://www.4women.gov/search/search/cfm)

Mental Health Association in
Utah
www.xmission.com/mhaut/

For information on medication while breastfeeding, call:

Pregnancy RiskLine
In Salt Lake:
328-BABY (2229)
Outside of Salt Lake:
1-800-822-BABY (2229)

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6–8 week postpartum examination. It has been utilized among numerous populations, including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than five minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items. Validation studies have utilized various threshold scores in determining which women were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be referred immediately for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel. Users may reproduce the scale without permission providing the copyright is respected by quoting the names of the authors, title and the source of the paper in all reproduced copies.



Instructions for Users

1. The mother is asked to underline 1 of 4 possible responses that comes the closest to how she has been feeling the previous 7 days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Name:
Date:
Address:
Baby's Age:

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

- | | |
|---|--|
| 1. I have been able to laugh and see the funny side of things
As much as I always could
Not quite so much now
Definitely not so much now
Not at all | *6. Things have been getting on top of me
Yes, most of the time I haven't been able to cope at all
Yes, sometimes I haven't been coping as well as usual
No, most of the time I have coped quite well
No, have been coping as well as ever |
| 2. I have looked forward with enjoyment to things
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all | *7. I have been so unhappy that I have had difficulty sleeping
Yes, most of the time
Yes, sometimes
Not very often
No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong
Yes, most of the time
Yes, some of the time
Not very often
No, never | *8. I have felt sad or miserable
Yes, most of the time
Yes, quite often
Not very often
No, not at all |
| 4. I have been anxious or worried for no good reason
No, not at all
Hardly ever
Yes, sometimes
Yes, very often | *9. I have been so unhappy that I have been crying
Yes, most of the time
Yes, quite often
Only occasionally
No, not at all |
| *5. I have felt scared or panicky for no very good reason
Yes, quite a lot
Yes, sometimes
No, not much
No, not at all | *10. The thought of harming myself has occurred to me
Yes, quite often
Sometimes
Hardly ever
Never |

BABY YOUR BABY BY PHONE

By Debby Carapezza, F.N.P.

The Problem:

Since the inception of the Baby Your Baby (BYB) Program (Prenatal Presumptive Eligibility [PE] Program) in 1988, women needing financial assistance for prenatal medical expenses could be screened for the program through any local health department or community health center. With the changing times, Salt Lake Valley Health Department and the community health centers in Salt Lake County became unable to provide Baby Your Baby screening for clients of private providers – those not entering their own antenatal programs. As a result, women residing in Salt Lake County and receiving their prenatal care through private providers were unable to be screened for Baby Your Baby and simply had to make a Medicaid application directly to either the Department of Workforce Services (DWS) or to a Bureau of Eligibility Services (BES) Outreach Worker. This could result in delaying the woman's entry into prenatal care – the very thing Baby Your Baby was designed to prevent!

The Solution:

To make Baby Your Baby available to all women in Salt Lake County, a means of screening women for the program via telephone was developed and initiated in June of 2001. For the first six months, it operated on a trial basis. However,

as of December, Baby Your Baby by Phone has become official and it is a great success. Since its inception in June, the program has screened 1, 119 women for Baby Your Baby!

How Does It Work?

Women planning to receive their prenatal care through one of the Salt Lake Community Health Centers – Northwest, Copperview, Oquirrh View or Central City – or via the University of Utah's Teen Mother and Child Program, U Family Health Center, Sugarhouse Health Center, or at the St. Mark's Family Medical Center, may still be screened for Baby Your Baby at those sites and they are urged to do so. However, a woman residing in Salt Lake County, **not** receiving prenatal care at one of the above sites and in need of financial assistance for her prenatal care, simply needs to call the Baby Your Baby Hotline at 1-800-826-9662. The Hotline will schedule an appointment for her screening. At the appointed time, the Baby Your Baby by Phone worker, housed within the Utah Department of Health's Reproductive Health Program, will call the client and complete the application process and explain the program to the client. If eligible, the client has her verification of pregnancy faxed to the Reproductive Health Program. Upon receipt of this pregnancy confirmation, the client's Pink Card (PE/BYB card) is mailed to her along with an instruction sheet, Medicaid application, and listings of her closest DWS and/or BES Medicaid Outreach Worker office where she can make her formal Medicaid application. If the client is not already on WIC, she is also referred to that program.

Telephone interpretation is provided at no cost for women with limited English proficiency. If the client does not have a phone, she may call the program at her scheduled appointment time from a site convenient for her. Those women needing a pregnancy test, but unable to afford one, are referred to free testing sites. These sites are also able to fax the test results to Baby Your Baby by Phone.

The average waiting time for a screening appointment can vary from three to eight days. Women with urgent medical needs are screened as quickly as possible – generally within one working day. If needed, and with prior arrangement, the Pink Card can be picked up by the client at the Cannon Health Building to avoid waiting for the card's arrival via mail.

For More Information, Questions, or Comments:

If you have questions or need more information, call Debby Carapezza, Nurse Consultant, Utah Department of Health's Reproductive Health Program, at 801-538-9946, Fax at 801-538-9409 or e-mail at: dcarapez@doh.state.ut.us

REMEMBER, to schedule a Salt Lake County resident for a Baby Your Baby by Phone appointment, call:

**BABY YOUR BABY HOTLINE
1-800-826-9662**



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REPRODUCTIVE HEALTH PROGRAM
PO BOX 142001
SALT LAKE CITY UT 84114-2001

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